THE ROBERT WOOD JOHNSON FOUNDATION

DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation

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Full Circle Diabetes Program

Building Community Supports for Diabetes Care

AADE Annual Meeting
Los Angeles, August 2006
Connie Norman

Full Circle Diabetes Program

- A collaboration between the Minneapolis American Indian Center, Native American Community Clinic and Diabetes Community Council
- Our mission is to build community supports for Native Americans ages 16 to 85 years living in the Twin Cities metro area of Minnesota who have type 2 diabetes

Full Circle Diabetes Program

- On-going Follow-up and Support
  - Framework
    - The Circle Model has promoted effective partnerships between the community center, clinic and council of Elders
    - Strengths of our framework promote OFUS
  - Specific Strategies
    - Clinic-initiated case management
    - Community-initiated talking circles

Strengths of Framework

- Expands program capacity for OFUS
  - Promotes a common mission across several agencies
  - Promotes holistic programming
    - Ensures that services are culturally appropriate
    - Increases variety of services addressing physical, mental, emotional and spiritual aspects of health
    - Patients are empowered to stay connected to programming through a variety of outlets
  - Increases total number of services
    - Increases opportunities for follow-up and support

Strengths of Framework

- Ensures community investment for OFUS
  - Leadership of the Chronic Disease Self-Management Program
  - Talking Circle Facilitation
  - Coordination of Intergenerational Events
  - Active Testimonial Outreach to patients

Strengths of Framework

- Builds trust and accessibility
  - Community-based education opportunities
    - Increases availability of providers
    - Keeps patients / participants connected
    - Encourages patients to seek clinical care when they are ready
    - Multiple entry points into the program

Clinic-Initiated Case Management

- Individualized care
  - Identification of patient specific needs
    - Physical
    - Behavioral
    - Emotional
    - Environmental
  - Development of action plans
    - Builds trust
    - On-going follow-up that promotes patient accountability

Clinic-Initiated Case Management

- Case Management Meetings
  - Engages diverse disciplines
    - Providers
    - Case Manager
    - Dietitian
    - Patient Advocate / Social Worker
  - Provides opportunities to triage patients
  - Fosters proactive care
  - Promotes delivery of consistent messages

Clinic-Initiated Case Management

- Active Outreach
  - Quarterly reminder letters promote timely clinic appointments
  - Referrals support patient specific needs
  - Advocacy ensures patient access to resources

Community-Initiated Talking Circles

- Led by community members living with diabetes
- Culturally appropriate resource
  - Honors the importance of spirituality
  - Builds strength by sharing personal testimonies
    - Provides opportunities to learn from the life stories of each other
    - Reduces barriers to understanding "because we speak the same language and share the same values"

Community-Initiated Talking Circles

- Impact of Chronic Disease Self-Management Program
  - OFUS for participants that have completed the Chronic Disease Self-Management Program
  - Facilitators of talking circles have completed the leaders training for the Chronic Disease Self-Management Program
    - Encourages on-going action planning

Key Lessons

- The Circle Model as an organizational framework promotes both clinic and community-initiated OFUS
- OFUS should be promoted through multiple strategies at the organizational, community and individual levels to best meet diverse patient needs.